Questions for Testimony - PMRI Terminology Users

DIRECTIONS:

- Please complete **BOTH** 'Terminology Specific' (3 questions) AND 'General' (6 questions) portions of the questionnaire for **EACH** terminology you intend to respond (see Terminology Selection Box below)
- The questionnaire will be considered your written testimony of which your oral testimony (10 minutes) will **highlight only** the important points of your questionnaire responses.
- Please return the completed questionnaire(s) in one separate e-file *per terminology* to: Michael Fitzmaurice **mfitzmau@AHRQ.GOV** **by 5/12/03** (Monday)

I. Questions for Testimony - PMRI Terminology Users 'Terminology Specific'

Name of the clinical terminology that you use:

SNOMED CT

(Select the above from the following list of clinically specific PMRI terminologies)

Terminology Selection Box	
SNOMED CT	**MedCin**
RX-Norm	**NCI Thesaurus**
LOINC	**NDDF Plus**
NDF-RT	**UMDNS - Universal Medical Device Nomenclature System**
SNODENT	**HL7 v3 Codes**
ISO Tooth Designation Codes	**ISO 11073**

1. **Check those applications or clinical processes that you use this terminology for**:

Laboratory Orders	❑	Nursing notes	❑	Drug orders	❑
Laboratory Results Reporting	❑	Physician notes	❑	Operative Notes	❑
Patient referrals	❑	History/Physical	X❑	ED Charting	❑
Other (name) Problem list	X❑	Other (name)	❑	Other (name)	❑
Other (name)	❑	Other (name)	❑	Other (name)	❑

2. **Please indicate the strengths and weaknesses of this terminology**.

	Excellent		**Adequate**		**Poor**
Overall usefulness as a PMRI (clinical) terminology	1	2	3	4	5
Adequacy of Domain coverage	1	2*	3	4	5
Clarity of Concept/term meanings	1	2	3	4	5
Usefulness of semantic hierarchy and/or terminology organization	1	2	3	4	5
Degree of non-redundancy (i.e. absence of multiple concepts with the same meaning)	1	2	3	4	5
Version control	1	2	3	4	5
Timeliness of updates	1	2	3	4	5
Availability and quality of user education	1	2	3	4	5
Responsiveness to adding new concepts, answering questions, providing support, etc.	1	2	3	4	5
Reasonableness and equity of licensure costs	1	2	3	4	5

*SNOMED is still working on adding nursing concepts, so domain coverage will improve with time. Over 1000 new nursing concepts were included in the SNOMED CT January 2003 release modeled from Home Health Care Classification, the Omaha System, and Nursing Intervention Classification (NIC). Previous releases have included nursing content from NANDA, and the Perioperative Nursing Data Set. The work of integrating nursing content from ANA recognized nursing classification systems helps to ensure rich content relevant to nursing practice within the operating room, acute care settings, and within the community that is integrated with the rest of health care.

**I have not had the opportunity to attend user education and so cannot evaluate it. I have learned to use the terminology through work on projects and collaborative efforts with the SNOMED International Editorial Board. I have attended four User Group meetings and found them to be very useful and good for networking—sharing ideas for use of the terminology.

***My work with the terminology has not yet required a license, so I am not able to evaluate the price.

List other strengths or weaknesses <u>briefly</u> and indicating score:

	Excellent		Adequate		Poor
Multidisciplinary nature	1	2	3	4	5
Nursing content coverage	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

3. **Do you map your terminology to another terminology to make applications successful**?

Yes	X❑	No	❑

Identify the terminologies that you map to, and describe the mapping method, product or service that you use:

I use Cerner PowerChart ©. This application uses a nomenclature tool so that each site may develop their own terminology to populate values for data elements. As I create interface terms I map them to SNOMED CT© to support consistent data retrieval and interoperability with other colleagues. This is a manual mapping using SNOMED CT© in the Clue browser to find the concepts of interest. Cerner is working on using SNOMED CT© in their applications. When this is done, I will be able to transition my forms so that they use SNOMED CT© instead of the local terminology I developed.

II. Questions for Testimony - PMRI Terminology Users 'General'

<u>If you have already filled out a previous version of this questionnaire for another PMRI terminology, you will see that some of the 'General' questions are redundant</u>. <u>For questions that are redundant, please indicate that you have already responded to this question in a previous PMRI terminology questionnaire</u>.

1. **Do you routinely use or provide subsets of the clinically specific PMRI terminology that you selected in the questionnaire titled I. 'Terminology Specific'?**

Yes	❑	No	X❑

2. What are the <u>features</u> of this PMRI terminology you use that make it easier or more difficult to later analyze the data you've collected (for example, extensive concept hierarchies with multiple inheritance paths are very important, whereas redundant representations of the same clinical concepts make analysis very difficult and unreliable)?

Easier to Analyze
The concept hierarchies with multiple parents are a plus. While we are too early in our use of SNOMED CT to have analyzed data, we do plan on using it to track the concepts that students have documented. This will give us a more thorough evaluation of the curricular content they have mastered.

More Difficult to Analyze
Not able to identify difficulties yet.

3. How easy have you found it to design user interfaces that capture coded data from clinical users? What user-interface mechanisms or techniques have you used to enable the capture of coded clinical data (e.g. pick-lists of coded terms, text-based search algorithms, natural language processing, mapping between distinct "interface" and "reference" terminologies, etc.)? Are there any specific features of this PMRI terminology that make it more or less amenable to structured data entry?

The CPR application I use has tools for doing all of these things. The concept of structured data entry is handled very well. However, my ability to capture coded data today is limited by the CPR application which relies on local, non-standardized terminology as its base. Therefore to attain the benefits of coded data, I map to SNOMED CT. I would expect that when the use of SNOMED CT is available to me, directly in the CPR, that design of interfaces and forms would continue to be straight forward. This would happen automatically result in coded data, saving me time and ensuring accuracy.

4. What gaps can you identify among the PMRI terminologies that you would like to see filled? What benefits would it bring? Please list with brief description:

Gaps	Description
Ability to handle goals	Goals are findings that you specify will happen in the future, yet they require a different terminology model than findings; they could also be said to be context dependent—the context being the future. SNOMED has plans to map goals from nursing classifications into SNOMED CT.
Ability to handle context dependent concepts, i.e., negation	These are concepts such as family history of X, medical history of X, no loss of consciousness. If a concept within each context must be added to a terminology, there will be a tremendous combinatorial explosion of terms and be very difficult to maintain. SNOMED is working on this issue.
Ability to handle outcome measures	Examples are Beck Depression Scale, SF-36, Nursing Outcomes Classification (NOC). There are many outcome measures in the field, but the question still remains how do we complete these measures and enter the data into the CPR. The question needs to be answered of whether this is a terminology issue or if these measures are standard enough that a score only needs to be recorded. Many of these measures involve clinical data that is already collected, e.g., pain ratings, toileting ability, activities of daily living. The SNOMED CT Context of Care work group has begun developing the terminology model for outcomes. Once this model has been approved, the Nursing Outcomes Classification (NOC) will be integrated.

Benefits	Description
Goals	These are essential component of a patient care plan and specify what the patient will achieve after interventions have occurred. In order to analyze data concerning patient care, it is important to know what the goals of care were and if they were achieved. The goals from the Perioperative Nursing Data Set will be integrated and released in July 2003. This effort will greatly enhance SNOMED CT's ability to support the nursing process and documentation needs.
Context dependent	Enhance search strategies and richness of the terminology if the combinatorial issue can be handled. More complete patient descriptions can occur as it is sometimes necessary to describe sentinel findings that are not there.
Outcome measures	The ability to incorporate outcome measures and the richness of data they represent will enhance knowledge about the patient, assist in effectiveness studies, and enable clinical decision rules to be developed.

5. Should the NCVHS recommend that the government (if selecting more than one, rank order by your priority in the last column):

Recognize and/or adopt one or more clinically-specific terminologies that can serve as the core set of national PMRI terminology standards	❑X	1
Analyze clinical functions and identify the gaps in existing terminologies for fulfilling these functions	❑	
Develop PMRI terminology standards to fill these gaps	❑	
Support existing terminology developers to fill the gaps	❑X	2
Do nothing in terminology development and let the private sector fill the gaps as it will	❑	
Develop a single master terminology from scratch	❑	

6. Please <u>briefly</u> list suggestions or comments that you have for the NCVHS. Also, rank order your suggestions by priority in the last column.

Company or Organization responding to questionnaire:

University of Kansas School of Nursing, Kansas City, KS

Individual responding to questionnaire:

Judith J. Warren, PhD, RN, BC, FAAN
Project Director of SEEDS (Simulated E-hEalth Delivery System)